36My interview with Dr Shankara Chetty from South Africa. Dr Shankara is an advoc.mp3

Date: 2023-03-20

Duration: 2147

Summary

Dr. Shankara Chetty is a natural science biologist and general practitioner who has been living in Port Edward, South Africa for the past 18 years. He has been a frontline worker during the COVID-19 pandemic and has been advocating for early treatment for the virus. He has been examining every patient with COVID-19 himself and has setup a tent outside his home to do so. He has been trying to understand why patients were getting into the hospital by looking at the symptomatology that was too far down the road. He has been asking patients to come in and see him as soon as they have a sore throat so that he can start the treatment early and understand the virus better.

In this conversation, the speaker discusses their experience with a subset of coronavirus patients who exhibited a strange and sudden deterioration exactly one week after the onset of the illness. The speaker noticed that the severity of the illness varied between patients, with some having mild symptoms while others were quickly becoming severely ill. This biphasic illness seemed to have no correlation between the first and second phases, leaving the speaker to investigate what was causing this sudden and unpredictable change. They concluded that it was not a typical pneumonia as it was progressing too quickly, and they began to examine the first few patients to try and understand what was going on.

The speaker discussed a group of patients that started presenting symptoms on the 8th day after feeling completely healthy the day before. These patients were not acutely ill and did not have the typical clinical picture of a

pneumonia. Instead, they were just breathless and unable to take a deep breath. The varying degree of severity from the 8th day onwards suggested that it was an immune response or a body's response to something rather than an infection. The speaker concluded that the only pathology that fits the picture of some people having no response and some having varying degrees of response is an allergic reaction to an allergen. Those not allergic to the allergen will have no response, those mildly allergic will have a transient reaction, and those severely allergic will have an anaphylactic reaction and end up critically ill.

Dr. Shamsi discussed the difference between different people's reactions to bee stings and how it can cause trauma. He noted that bee sting allergies are not dependent on any comorbidities, such as high blood pressure or diabetes. He then noted that in this pandemic, it was important to identify the cause of the illness early on, as it can cause damage to multiple organs if left untreated. As a result, he began using steroids as the mainstay of treatment for his patients as it is a steroid responsive illness. He then used antihistamines to help mop up the mediators that were released when the reaction started. He was able to help the critically ill patient, who was diabetic and hypertensive, by combining the use of steroids and antihistamines.

Timestamps

Transcript

[0:00:17] **A**: Thank you.

[0:00:19] **B**: Lisa Johnston with Australian National Review. I'm speaking with Dr. Shankara Chetty from South Africa. Hello, Dr. Shankara. How are you?

[0:00:28] **A**: Fine. Thanks, Lisa. I hope you're doing fine as well.

[0:00:31] **B**: Thank you for joining me. I wonder if you can do a brief introduction of what you do, what you'll specialize in, and just introduce yourself for our viewers.

[0:00:41] **A**: US. I'm a natural science biologist and general practitioner. I live in Port Edward, South Africa. A little boutique holiday village. I've been here for the last 18 years practicing family medicine, and I have been a frontline worker with this corona pandemic from the start, from the onset of this pandemic. And my work as a frontline doctor has brought out many

nuances of the pandemic that have highlighted the kind of pathology we're dealing with that has allowed me to fine tune early treatment options.

[0:01:15] **A**: And so I'm a big advocate for early treatment for coronavirus. We've had some great success. We've understood the pathology of COVID and yeah, that's brought me to center stage.

[0:01:27] **B**: Can I ask what treatments what early treatments you would be using and have used?

[0:01:34] **A**: I think, Lisa, the understanding of the perspective, the understanding of the pathogenesis of COVID is vitally important in understanding how to treat this illness. There's been a lot of different treatment protocols out there, but it's a lot of try this and try that and see what works. Just to give you a perspective of how I came to where I'm at with the pandemic itself, I endeavored from the start to examine every patient that had coronavirus physically myself.

[0:02:00] **A**: And so I moved out of my home, and I set up a tent outside my home where my practice actually is, and I made sure I examined every patient. I wanted to understand why people were getting into hospital. Hospitalization patients were critically ill, and the symptomatology was too far down the road. I needed to understand what was changing and getting them into hospital and breathlessness was the issue.

[0:02:23] **A**: So I asked every patient to come in and see me as soon as they got a sore throat so that I could start early and understand this. Very early on in the illness, I found that there was a subset of patients who wasn't, and it was those patients that I was interested in to understand what brought on the spreadlessness and what ended up with patients being ventilated. I noticed a few very unusual nuances early on.

[0:02:51] **A**: The subset of patients that came back, I'd say about 30% of patients started to experience this difficulty. It always seemed to happen exactly one week after they started to get ill. And that seems strange that exactly a week after you started to feel ill that you'd suddenly deteriorate. That was unusual as well. These patients that came in breathless on inquiry the day before the breathlessness started, they actually felt well.

[0:03:20] **A**: So it seemed like they were having a viral illness that seemed to be self limiting. By the fourth or fifth day, it seemed that their bodies had managed to overcome this. They felt improvement, signs of recovery. And then, strangely, in a subset on the 8th day, exactly a week after the onset, they started to notice breathlessness, the breathlessness that they noted as well. In that subset of patients, the severities seemed to vary. Some had mild, some moderate, and some rapidly progressive, severe breathlessness.

[0:03:53] **A**: So I started to notice very early on that we're dealing with a biphasic illness, two separate phases here that seemed to switch exactly on the 8th day. And there was no linearity, there was no correlation between the first and second phase, meaning that patients who were severely ill in the first phase did not necessarily progress into the second phase. And there were those that had very mild illness in the first phase recovered from it completely, and on the 8th day suddenly started down the road on the second phase of illness.

[0:04:24] **A**: So we were dealing with something really strange. Now, in the first five patients, I started to look at that, the first five patients that presented back and try and understand what was going on here. Now, the world was talking of COVID pneumonia. Now, a pneumonia is a steadily progressive illness. A pneumonia is not something that just starts up in the morning and has you in ICU by the evening. So I started to examine these patients who presented back to try and understand exactly what was going on with them.

[0:04:56] **A**: Now, clinically, these patients that came in on the 8th day were not acutely ill. In fact, the day before they were feeling fine and they were generally breathless and fatigued. But on examination, they didn't have the typical clinical picture of a pneumonia. They weren't acutely ill, they didn't have restriction to airflow, they didn't have any crepitations or other sounds in their lung, so they were just breathless. And all of them reported that they couldn't take a deep breath, yet they could breathe rapidly and easily.

[0:05:27] **A**: It was just a deep breath that seemed to be restricted. Now, looking at that presentation, I was under the impression that we're not dealing with an infection anymore, we're dealing with an immune response or a body's response to something. And in trying to understand that, the varying degree of severity from the 8th day onwards seemed very unusual. I had healthy patients with no comorbidities on the 8th day start to get critically ill.

[0:05:58] **A**: And I had patients that were very old with diabetes and high blood pressure and all the comorbidities you can speak of that had very mild symptoms, recur on the 8th day, and seemed to recover from it relatively easily. So I noticed that the comorbidities weren't playing a part in the second phase of this illness. And so I started looking at what possible pathologies could allow me to understand what this possibly is.

[0:06:24] **A**: And the only thing that fits that kind of picture where you have a majority of people not having a response and then those that respond responding in varying degrees. The only pathology that works in that way is an allergic reaction to an allergen, like an allergic reaction to a beasting. So

some of us are not allergic and nothing will happen. Those that are mildly allergic will have a transient reaction, those that are severely allergic will border on anaphylaxis and end up critically ill within the day.

[0:06:56] **A**: And that's what I was seeing, this difference in different people. And of course, beasting, the allergy to a beasting is not dependent on any comorbidity. So bee doesn't care whether you're fatother or whether you have a high blood pressure or diabetes. It only cares whether you're allergic to it sting to cause trauma to you. And so, looking at that, I knew that I'm dealing with what I'd call a type one hypersensitivity kind of reaction that was initiated by something on that 8th day and those that were allergic were having a severe reaction or, well, a very degree of reaction and that needed to be stopped.

[0:07:31] **A**: And of course, that is where all the mortality and morbidity in this pandemic lay in that second phase. No one's been admitted to hospital in the first seven days. With the viral part of this illness in hospital itself, I think we were getting to the scene of the crime a little too late. If you came to me with a beasting critically ill and I advise that you isolate yourself at home and watch and see how this goes.

[0:07:56] **A**: In a few days you would have caused damage to multiple organs in your body and by the time you present to hospital, you'll be critically ill. The doctor there would probably notice all the multisystem disorder that you suffer with. And of course, he is unaware that you were stung by a bee a few days ago, so the treatment will not follow the pathology. So very early on understanding that perspective, I used steroids. Steroids were the mainstay of treatment. We knew that steroid, this is a steroid responsive illness, I knew that I have to choose very carefully where to put them in. And of course, the eight day became very obvious.

[0:08:34] **A**: So I initially started treating patients with steroids. It took three or four days for them to show good recovery. And so I understood that speed to recovery, in everything you do, speed to recovery, the quicker their recovery, the recovery, it points to mechanism because of the medication you used. So, in about the fifth or 6th patient, I had a 40 year old come in that's diabetic and hypertensive obese and presented on the 8th day critically ill with saturations close to 80%.

[0:09:03] **A**: So this was one of the more critically ill patients I had encountered. So I decided that I'll start on the steroids. But seeing that my thoughts were around hypersensitivity, I decided to treat it as such. Now, steroids tend to stop the reaction, but they don't mop up the mediators that were released when this reaction started. So antihistamines, Montalu, Cast,

all those kind of drugs are used when someone comes to me with the reaction with beasting.

[0:09:31] **A**: So I gave her a kidney's dose of antihistamine to see what would happen and just for a single day. And I got my staff to contact her the next day. And the next day she was perfectly fine, everything had settled, but I understood that there's going to be a rebound because I hadn't given her a long enough course. And as I predicted, the next day breathlessness started again and I called her in, put her back on the meds and she recovered completely.

[0:09:57] **A**: And so I understood I'm dealing with hypersensitivity on that 8th day and so my treatment has centered around that perspective. I added an antihistamine to the steroid, I added Montelucast, which mops up leukotrines, I added Aspirin, seeing that we were dealing with coagulation problems later on in the illness itself. And that became the mainstay of treating. I had recoveries within a day. So even patients that came in critically ill showed signs of improvement in their oxygen saturations, which was the big problem within a period of a few hours.

[0:10:33] **A**: Now, steroids took three days to show some improvement, antihistamines showed it in a few hours. So I was under the impression I had gotten to the root of the problem. Now I needed to figure out what was causing this problem. On the 8th day we were told that this is a bat coronavirus that jumps species to human beings. And as human beings, we've been exposed to coronaviruses for quite a period of time, so nothing should be new there.

[0:11:00] **A**: But the one thing that would be new if a bad coronavirus jump species would be spike protein. Spike protein is what attaches this virus to its human host. And if that changed, well, it had an affinity for humans. And I thought, well, when you're exposed to something new, you develop an allergic reaction in a subset of population, so it's likely to be spiked protein triggering this allergic process because it's the only new thing on this virus.

[0:11:25] **A**: In the second wave we had the notorious South African variant that caused a lot of mortality and mobility. It seemed to be a very dangerous variant, so I took the opportunity to compare the wild type with the South African variant. I have a background in genetics and so that helped me in good stead. The only change in the variant was a mutation that caused a change in spike protein. So the only thing that changed was spike protein.

[0:11:53] **A**: Now, looking at the clinical picture, in the second wave we had a variant that was more contagious spike protein, better affinity for a host. I saw more gastroenteritis as a presentation initially spike protein again affinity for ace receptors in the gut and on the 8th day. In some patients I

had a far more severe allergic reaction compared to the first wave. So that showed me that the allergic reaction was definitely being triggered by spike protein.

[0:12:23] **A**: And of course, the severity of that allergic reaction would determine the mortality and mobility of that variant. So far more severe reactions, far more dangerous variant. And so my focus shifted to spike protein. I was still seeing the benefits. I was in the first wave and so in the second wave, the treatment modality remained pretty much the same. And so my focus has since been on spike protein. In all the patients that I've seen, I'm closer to 8000 patients now.

[0:12:53] **A**: And of course, I've had to see some very critically ill patients. Everyone's terrified of being put into hospital. They feel they don't come back from there. So even the most critical patients that presented to me insisted that I treat them and not hospitalize them. So even in the most critically ill patients, I've had good recoveries. In all the patients I've seen thus far, all those that I've engaged in home treatment with my protocols, I've not had a death, I've not had any hospitalizations, and I don't keep oxygen in my practice. I don't see the need for it. I think if you reverse the hypoxia timelessly, you negate the need for oxygen.

[0:13:32] **A**: Subsequently, there's been a lot of research that has centered around my findings. There's been research that showed that we are dealing with hypersensitivity, there's research that has shown that it is type one. And of course, the clinical picture has shown that it does get triggered around that 8th day. So I think the science is out there and the treatment protocol should follow that science. And if it does, we get good clinical recoveries of patients.

[0:13:59] **A**: So I don't see why anyone should have died from this pandemic. Proper early treatment could have saved all those lives. So that's made me a big advocate for early treatment. I think it's just that doctors have been terrified to watch patients die, not knowing what to do, and so they are very scared of trying new things. But of course, when a patient starts to recover within a few hours of initiating treatment, that builds confidence.

[0:14:25] **A**: And so I've been trying to advocate to doctors to start early treatment.

[0:14:30] **B**: Antihistamines.

[0:14:32] **A**: Antihistamines. Yes.

[0:14:34] **B**: Great. So can I ask your thoughts on the vaccine? We seem to have a major push for it down under and I wanted to know your thoughts on that.

[0:14:45] **A**: When I published my initial article to give understanding to the perspective, I did say that it became very controversial just for one statement. I said that if early treatment could negate all the mortality and mobility in this pandemic, it would make mass vaccinations wholly unnecessary. And of course that caused all the controversy and I couldn't understand why that would be a controversial statement. After all, it would make it easy to stop this pandemic.

[0:15:14] **A**: We'd all develop natural immunity after infection and we wouldn't have the need for vaccination. But of course, my comments on vaccination proved controversial. Now, when you look at the vaccination campaign that's out there, there's a few things that I find very nonsensical. In fact, the entire public health strategy, first, from a public health intervention strategy. In all of human history, we have never been able to curtail the spread of a respiratory virus through lockdown measures and isolations.

[0:15:47] **A**: It's airborne and so you can't see it. And so locking people down will never be able to stop its spread. People will move and if you can't identify it, then you don't know what you're locking down. And so you got a faulty PCR test. That's like having bad eyesight trying to locate a virus. You'll never win because you have to identify every case and isolate it to try and stop it spreading. All you need is one case out there that's not identified and it's going to spread.

[0:16:14] **A**: So we're sitting with a faulty PCR test. We're sitting with a measure that's never worked in all of human history. It seemed nonsensical to go down that road. Then from the perspective of vaccines, we've never been able to develop an effective vaccine against an RNA virus. RNA viruses tend to mutate relatively quickly and developing a vaccine has never shown benefit. We do this on a yearly basis with the flu vaccine and it's only been shown to be about 20%, 20% to 30% effective because the strains of flu are too far and too diverse for a single vaccine to actually solve the problem.

[0:16:57] **A**: And that seems strange that we would go down that road with the pandemic and make it our primary strategy to try and curtail all this madness we were seeing around us. So from the start I thought the strategies for public health were nonsensical. They were almost destined to fail. And I mean, history is repeating itself so we should fall back on our knowledge and not try and call everything novel. There's nothing novel about it. We got a lot of education around viruses.

[0:17:24] **A**: Now, the development of the vaccine is a little strange as well. Traditionally we have certain techniques that we use to develop vaccines and the commonest is to take the virus itself and either develop an inactivated viral vaccine or a live attenuated vaccine. Now, a heat killed vaccine, you give it to everyone, it's broad and diverse because they get the entire ambit of the virus into their body.

[0:17:55] **A**: And so that stimulates a broad, diverse immune response with a whole host of antibodies to every part of that virus. And so you got a good robust antibody response. And we find with that we add adjuvants and things like that that would keep that immunity long lasting. The other method would be to take the mildest strain of a virus, keep it alive, but inactivate its potential to cause attenuate its potential to cause illness.

[0:18:25] **A**: So you'd have a virus that causes mild illness and you develop immunity. And so a vaccine that has that potential live attenuated also has the potential to spread between people. So you don't need to vaccinate everyone. You vaccinate one person and they would get slightly ill and go home and spread it to everyone else and everyone would have a slight flu and get over it and we'd develop herd immunity that way.

[0:18:50] **A**: So that would be the pragmatic ways of doing things. But it seemed companies like Pfizer and Moderna and the rest had new technology up their sleeve and of course there's the financial gains to be made with that and so they decided they would use the Spike protein to develop antibodies. Now, as soon as that came to the fore, I thought it's a very dangerous game to play because I realized that Spike protein is a toxin here.

[0:19:15] **A**: Spike protein was already causing the allergic reactions on the 8th day. And so why would you use something that is already shown to have problems in the development of a vaccine? You got the whole virus to work with. Why work with the one part that's new and unusual? So with the development of the mRNA vaccines I was very concerned that we're going to trigger a host of problems here. And of course, my understanding that we're dealing with an allergic process on the 8th day and the fact that it took me this long to get the scientific and medical world to understand that means that we don't understand the immunology around the virus very well.

[0:19:57] **A**: Now, if you don't understand the immunology around the virus, it really would be foolhardy to go and affect the immunity of a planet with a vaccine without understanding how the natural infection immunology actually works. You don't know where to intervene. So I was very concerned with these vaccines and of course they didn't make sense to me. If you look at the messenger RNA vaccines, if I had to simply explain what they meant to do you are injecting a person with messenger RNA, which is a message to

make Spike protein and of course a single kind of Spike protein being the wild type from the initial virus that was used to make the message.

[0:20:41] **A**: So the message will only get the wild type Spike protein made. Now, that messenger RNA gets into your body, it gets into a cell, that cell is then hijacked to make Spike protein. When your body makes that spike protein your immunity recognizes it as a foreign substance, then stimulates an immune response and develops antibodies to the Spike protein. Those antibodies, if they are neutralizing, will then hold you in good stead. When you exposed to the virus they will bind the Spike protein on the virus and give you immunity in that way.

[0:21:19] **A**: So that's the science behind what this vaccine is meant to do. Now, that seemed nonsensical to me for a few reasons. One, spike protein from the wild type is not going to work on any other variate because the mutations seem to be in the spike protein itself. Secondly, it seemed very contrived. Now, if you're going down this road using messenger RNA to stimulate immunity, it begs the question messenger RNA is new technology.

[0:21:51] **A**: We didn't know whether it's going to stay in your arm or distribute through your body. We didn't know how much of it is going to get incorporated into cells, we didn't know how much of spike protein would be produced and we didn't know for how long. So all these variables make it a poor choice for a well dosed vaccine. So I asked a simple question. After all, it's the spike protein that's triggering the immune response that we require with this vaccine.

[0:22:23] **A**: So why don't you inject people directly with spike protein? You could control the dose, you could control everything, and you'd get the same endpoint. You give someone a spike protein injection, your body will recognize it as foreign, you develop antibodies to it and those antibodies will hold you in good stead. So I couldn't understand the purpose of the messenger RNA in this picture. Why would you need to turn the body into a factory for spike protein when you could just inject spike protein and get the same outcome? So a lot of it seemed very nonsensical, and I think a lot of this was meant to confuse the general public because it seemed from the start that vaccines needed to be pushed early. I saw from the start that early treatment was suppressed, anyone that spoke out was censored and so I've been very cautious not to get involved with the governmental structures.

[0:23:14] **A**: I felt that if I educated doctors about the perspective and taught people about the 8th day and so they could understand when to present and what to do, I wouldn't have to ask anyone's permission to save lives. And so I've kept this quietly to myself and spread it amongst doctors and public so that I don't get the or encourages a wrath of the governance

structures around me. So I'm of the opinion that the vaccine is actually completely useless.

[0:23:40] **A**: It will work against the wild type variant which has long gone. We're not seeing any immune benefit from the vaccines. In my practice in the last third wave, I've seen numerous patients come in with breakthrough infections. So if this vaccine was meant to protect you, it surely isn't and it should, as a vaccine, protect you from infection. And I think it doesn't work at all when it comes to what it should do.

[0:24:10] **A**: So is it a vaccine?

[0:24:12] **B**: Dr. Shankara we're getting a lot of people who are silenced worldwide, not just down under, but those who are experiencing side effects and adverse reactions. Can you tell me what you've seen in your practice or from what you've observed yourself with side effects from the vaccine.

[0:24:33] **A**: Okay, just to put some context to what the vaccines are doing in the first place, a vaccine should stimulate immunity, meaning it should prevent infection and prevent transmission. Infection and transmission have a lot of variables around them, meaning that if you're highly transmissible, but standing across the road from me, it makes no difference. But if you're mildly transmissible in a crowded room, then you're going to transmit it to everyone.

[0:24:59] **A**: So a vaccine is meant to stop infection and stop transmission, not decrease it. There's no in betweens here. Now, very clearly with this vaccine, we've seen that it doesn't stop infection and transmission. Even the CDC and the FDA and the drug manufacturer or the vaccine manufacturers themselves have admitted that it doesn't do that. If it doesn't do that, then it doesn't have a population benefit. Means if you take the vaccine and it prevents you getting infected or transmitting, then you protect me.

[0:25:30] **A**: If it doesn't do that, then you don't protect me. So we need a group or population benefit from a vaccine. Now, these vaccines haven't proven that, so that shows that it doesn't give you a sterilizing immunity. That means the antibodies that these vaccines make are non neutralizing to the virus. They do not kill the virus. Now, there's this claim that it prevents severe illness and death. Now, that claim, that is a therapeutic benefit.

[0:26:01] **A**: It is not a vaccine benefit. My treatment prevents severe illness and death as well. And my treatment is restricted to sick people. I do not expose the entire planet to the side effects of my treatment. I only expose sick people. So the vaccine should be classified as a therapeutic. After all, it's a gene therapy. It's the first time messenger RNA is used in the vaccine field. It's always been gene therapy.

[0:26:31] **A**: So you got to put it into the right context. This is a therapeutic, and we haven't proven that it prevents severe illness or death. They want me to do randomized clinical trials to prove that my medication works. Why isn't it the same playing field for a therapeutic mRNA intervention? And even if this vaccine has the potential to prevent severe illness and death, that is an individual benefit. So if you take the vaccine, you won't get severely ill or die.

[0:27:03] **A**: That does not confer any benefit to me. So why am I being forced to take it? To protect you. The mandates make absolutely no sense. Now, coming back to the side effects, we got to look at spike protein very closely to understand what's going to happen with this. After all, Spike protein is the pathogen of COVID illness, not coronavirus. So coronavirus does cause a mild transient viral infection, but the mortality and morbidity of COVID illness resides in the pathology that's caused by Spike protein.

[0:27:43] **A**: So Spike protein is the primary pathogen of COVID illness. So we got to understand how this causes pathology. Now, a lot of the work that I've been pushing research to get into is into the biologic effects of spike protein because the vaccine is going to expose you to a long term spike protein. The virus exposes you on the 8th day to a transient dose of spike protein. Now of course, the transient dose, the first thing it can do is in those that are allergic, trigger an allergic reaction.

[0:28:19] **A**: However, longer term exposure would bring out its biologic potential. Just to put that into some context, penicillin, the biologic effect of penicillin is an antibiotic. But for me to get that biologic effect I got to expose you to a full course. Now, if I took a single tablet of penicillin and I gave the entire planet one dose, it won't act as an antibiotic, it's too mild. But if I folded my hands and waited, every person that was allergic to penicillin would have a reaction and if I did not treat them, some would die.

[0:28:51] **A**: And that's what the virus has done. However, the vaccine is the full course, so you're getting a full exposure. Now, I need to understand what its biologic effect is going to be with that long term exposure and that's been my focus. So I've been watching vaccinated people very closely to try and understand what's going on here. Now, we know a lot of research has come out recently looking at the structure of spike protein, its similarity to other biologics and what the potential for harm might be.

[0:29:24] **A**: Now, we know that spike protein causes allergy and that's usually the first thing that happens in those that are allergic. But if you're not allergic you will still be exposed to the biologic activity of it like penicillin. It's going to be an antibiotic if you take it. So the spike protein

we've seen causes endothelial inflammation, that's inflammation of your vessel linings that inflammation of vessel linings would result in clotting.

[0:29:49] **A**: And so we'd expect to see an increase in clotting events. So strokes and heart attacks and deep vein thrombosis and pulmonary emboli, those kind of issues. We've also seen that spike protein causes inflammation of myocardium through an immunologic damage. And so we expect to see an increase in myocarditis and pericarditis and that kind of inflammation then the structure of spike protein has shown that it has similarities to other pathologic proteins that are encountered.

[0:30:21] **A**: It's shown similarities to prions. Prions are infectious proteins that are implicated in Alzheimer's, dementia, neuropathies, that kind of thing. And so we'd expect to see changes in that direction. We also know that there are similarities to HIV proteins which result in immunosuppression. And if that occurs, immunosuppression is going to lead to a reemergence of latent illnesses in its host or a reemergence of cancers that were in remission. Your immunity is actually what keeps those two things at bay. And if you suppress your immunity you'll get reemergence of those kind of things.

[0:31:03] **A**: Of course, suppressing your immunity will also make you prone to. Developing the infection repeatedly or more severely. And so we were expecting to see those kind of things happen as well. Spike protein is a membrane protein. And so when your cells make spike protein, they actually express it on the surface of the cell, thinking that this is part of their membrane. Now, those cells that express it, we know that it distributes throughout the body.

[0:31:31] **A**: So you're going to have a variety of tissue around your body expressing spike protein. Those tissues that express it are going to be recognized as foreign and as such, they will trigger a host of autoimmune responses. And so we expected to see this diversity of pathology. And of course, there's two places to look in long term exposure to this. One would be long COVID and the other would be vaccine side effects.

[0:32:02] **A**: Now, I'd say that the numbers don't add up, but of course the numbers are not really necessary to examine. The spread of pathology is more important. And we've seen that with the long COVID and more importantly, the vaccine side effects, we've seen the clotting issues, we've seen the myocarditis, we've seen the neuropathies, we've seen the worsening of Alzheimer's and dementia in those patients. We've seen the suppression of immunity and the resultant sudden reemergence of latent viruses like herpes, zoster, cytomegalovirus, respiratory sensitivity of viruses.

[0:32:50] **A**: We've also seen a sudden reemergence of cancers in patients who are in remission. We've also seen the start of autoimmune conditions CJD, gillian Barray, which are very rare conditions that now have seen an uptick. So the pathology that we see is exactly what was predicted from our understanding of spike protein. Nothing new. There one new finding with spike protein that's really worrying is that it has the ability to enter the nucleus of a cell and in so doing suppress the Bracha gene.

[0:33:28] **A**: Braca is an important mechanism for repairing your DNA and so this might impact on the DNA's ability to repair itself. And so that's another huge problem that we might have to deal with with these vaccinations. Now, all that I've spoken about so far only deals with spike protein. It does not deal with the messenger RNA and the consequences of its integration into your DNA or the rest. It does not deal with the adjuvants in this vaccine that haven't been tested on human beings and the problems they would cause.

[0:34:00] **A**: And it doesn't include any side effects or effects of substances like graphene oxide or other parasites that we found in these vaccines. So just spike protein alone is enough for us to consider these vaccines highly toxic and to stop them immediately. But that's not happened. So I think an understanding of the vaccine is vitally important for people to make informed choices.

[0:34:26] **B**: Here in Australia, Dr. Shankara, there is a major push for it and they are now talking about booster shots. Obviously, a lot of us are quite concerned with where that's going to lead and probably more booster shots. Where do you see this heading and what's going on over in South Africa? What's your percentage of vaccine rates?

[0:34:49] **A**: Look, we have a low percentage of vaccination here. I think it's about 25% right now. But I think we need to understand that the vaccine campaign globally has nothing to do with public health. If you got a vaccine that hasn't shown any benefit from a health perspective, actually, in certain countries, they're finding that the vaccine has killed more people than COVID has. And so how can we still be attempting a public health intervention when it shows that it's actually detrimental to public health?

[0:35:21] **A**: So I think it's vitally important to understand the perspective. There's a bigger game at play here. Everything was nonsensical from the start, and everyone is constantly arguing about the lack of sense, the lack of knowledge. But I guess if you understand the big picture, then you understand why it happens. Everything becomes logical. I think this is more about the curtailment of freedoms.